



KANSAS
MEDICAL GROUP MANAGEMENT ASSOCIATION

Application for Membership
(Please type or print)

Name (First, MI, Last) : _____ Nickname : _____

Title : _____ Year Appointed : _____ Credentials : _____

Employer / Group Name : _____

Business Address : _____

Business City : _____ State : _____ Zip Code (9-digit) : _____

Business Phone – Voice : () _____ Fax : () _____

E-Mail Address : _____

Type of Practice (SS – single specialty, MS – multi specialty) : _____ # of Physicians (full or part time) : _____

Specialty (if single specialty) : _____ # of Employees (full or part time) : _____

Brief explanation of your duties : _____

MEMBERSHIP CATEGORY APPLIED FOR:

_____ Individual: May be held by one who performs managerial duties in multiple areas, or performs administrative tasks in one area, or provides patient care and also performs significant managerial or administrative tasks. Must work for a group or solo medical practice located within the State of Kansas or for a management organization that is contractually responsible for the day to day administrative and related support services for one or more group practices of 2 or more FTE M.D. or D.O. physicians located within the State of Kansas. An Individual Member is entitled to all Association membership services, including the right to vote, to serve as an officer of the Association, and to serve on any committee.

_____ Allied: May be held by one who is not eligible to be an Individual Member and who is providing management consulting services to medical practices located within the State of Kansas. An Allied Member may not vote or serve as an officer of the Association and may not serve on committees or attend the business meetings of the Association.

Applicant Signature : _____ Date : _____

Please attach a check payable to KMGMA for the appropriate category: Individual - \$75.00 Allied - \$200.00

**MAIL TO: Claire Daniels, Executive Assistant
KMGMA Membership Committee
5051 E. Lincoln, #4C
Wichita, KS 67218**

**Phone: (316) 686-4414
E-Mail: cdaniels1@cox.net**

Approved – Date : _____ By : _____

Personal Information for Membership Directory Only (optional)

Home Address : _____

Home City : _____ State : _____ Zip Code (9-digit) : _____

Home Phone : (_____) _____ Spouse Full Name : _____

Other Information

MGMA Member? (Y/N) : _____ Where should mail be sent? (Work/Home) : _____

Are you a member of a certified rural health clinic? (Y/N) : _____

If possible, name two KMGMA members who know you : _____

Are you a previous member of KMGMA? (Y/N) : _____ If so, when? _____

Name of Practice : _____

Was your membership under a different name at that time? (Y/N) : _____

If so, what was the name? : _____

Where did you hear about KMGMA? : _____
_____ Another KMGMA member
_____ Advertising
_____ Physician in our Practice
_____ Other (Please explain) _____